GOVERNANCE & OVERSIGHT NARRATIVE

Local Authority: Bear River Health Department

Instructions:

In the cells below, please provide an answer/description for each question. **PLEASE CHANGE THE COLOR TO BLUE, OF SUBSTANTIVE NEW LANGUAGE INCLUDED IN YOUR PLAN THIS YEAR!**

1) Access & Eligibility for Mental Health and/or Substance Abuse Clients

Who is eligible to receive mental health services within your catchment area? What services (are there different services available depending on funding)?
As a substance use treatment facility we do not receive funding specific to mental health disorders alone, however we evaluate our substance use clients for dual-diagnoses, including mental health issues and suicide risk, and address those co-occurring issues in tandem with substance use treatment. For those individuals with only mental health treatment needs, who are unable to access treatment through other agencies, we have provided treatment through a Utah Department of Health, State Primary Care Grant Program (SPCGP), Mental Health Services grant. This funding enables us to fill the gap in our community for non-Medicaid individuals who cannot afford private therapy. Clients eligible for this subsidized care must live in the local catchment area, must have non-substance related issues, must be uninsured or underinsured, and must qualify according to poverty level guidelines with an income at or below 200% of FPL. Treatment is provided on a cost for service basis, with the grant offsetting expenses. We are not using dedicated Substance Abuse funding for these services, and are relying on third party payers and client fees to augment this specified grant. Our mental health services include assessment and evaluation, outpatient treatment, family intervention and counseling, MRT, EMDR, Seeking Safety, Domestic Violence counseling, life skills and anger management education groups. We have applied for and been awarded this grant for several years, and have again submitted a proposal this year. If funding is renewed, we will continue this service in the coming fiscal year. Individuals with Medicaid coverage who are seeking mental health services only are referred to Bear River Mental Health (BRMH) as the local Medicaid mental health services provider. We coordinate closely with BRMH to ensure appropriate referrals are made and clients do not receive duplicate mental health services.
Who is eligible to receive substance abuse services within your catchment area? What services (are there different services available depending on funding)? Identify how you manage wait lists. How do you ensure priority populations get served?
To qualify for subsidized services, basic eligibility criteria must be met: 1) Individuals must be experiencing issues related to substance use or co-occurring disorder. 2) Clients must be at least 18 years of age and of legal competency, **OR** have a signed consent for treatment from a legal guardian. 3) Individuals must reside in the catchment area. To qualify for a specifically funded program, individuals must meet criteria for that program. For example, to enroll in the Drug Court, clients must meet First Judicial District Drug Court eligibility requirements. Individuals convicted as sex offenders or who have convictions for violent crimes will not preclude admission, however, these cases are staffed as to appropriate care and contact with other clients. If a threat is made or an offense committed towards staff, another client, or Health Department

facilities, the client's status will be reviewed and he/she/they may be discharged from the program.

All clients have access to all applicable services based on client needs: assessment and evaluation, intervention, and applicable ASAM level of care. Funding program allowances and monies available are taken into account when determining services to be provided. Some services in specifically funded programs are limited to funding allowances for those programs, e.g.: PATR is limited to State approved services; or, intensive outpatient care (IOP) may be attempted first if residential funding or bed space is not available; or, women's vouchers may only cover the cost of intake for women who are pregnant or have dependent children, according to funding availability.

If funding is depleted during the year, we will continue to provide services to existing clients, however services may be adjusted based on budget constraints. We do not utilize wait lists. We schedule first contact/intake appointments using a calendar of set-aside appointments, then when these are filled, we move to regular staff schedules, including looking at cancellations and broken appointment slots. Priority populations such as women, youth, and IV users are scheduled within 48 hours, if the client is able. We also treat self-referred and those referred from community partners as priority. Priority populations are not turned away due to expended funding, though level of care may be adjusted. To further employ the example above, if a female with dependent children met criteria for residential care but women's funding was expended and she did not qualify for other funding sources, she may be placed in intensive outpatient care. Programs such as jail services continue regardless of funding to ensure our commitments to community partners are fulfilled.

What are the criteria used to determine who is eligible for a public subsidy?

Individuals applying for services at a subsidized rate must meet the basic criteria listed above as well as any criteria for the specific funding source. Third party payers and client copays are utilized before resorting to public subsidy. To be eligible for public subsidy, clients must allow BRHD to bill and collect from third party payers such as insurance or other available assistance.

How is this amount of public subsidy determined?

The amount of public subsidy is determined by the client's income, available assistance from family, clergy and community, and other third party sources such as insurance, Medicaid and Medicare. BRHD uses a sliding fee scale to determine client copays, established using comparative research, Federal Poverty Level guidelines, and fees approved by our local Board. Client co-pay amounts are based on income, family size, and insurance qualifiers. Additional adjustments include emergency or uncommon hardship expenses such as loss of home, ongoing or extreme medical expenses. Other factors affecting the amount of subsidy allocated for each client are: level of treatment needed (residential vs. outpatient) and auxiliary services required (such as medication management or daycare assistance). These additional factors vary according to each client's situation, and amount of funding available from the funding source.

How is information about eligibility and fees communicated to prospective clients?

When scheduling an intake, whether by phone, in person, or in a venue such as court, staff ask questions that may affect eligibility to a specific funded program and client cost, including: actual service(s) the client is seeking, insurance coverage, acceptance to a program such as Drug Court, or female with dependent children. During intake, financial information is gathered from the client which includes income, family size, uncommon expenses, insurance information, financial support from other sources, and qualifiers for a specific funding source. Staff reviews with the client: funding source requirements and options specific to that client, the sliding fee scale, other costs (UA's, workbooks, etc.), and insurance co-pays. The client reviews, signs, and is offered a copy of the payment

agreement which provides written information regarding costs, payments, and authorization to bill third party payors. Staff makes a payment arrangement with the client, if needed, and the client is encouraged to discuss any changes in income or financial situations, or challenges in paying his/her/their co-pays so additional payment arrangements or adjustments can be made.

Are you a National Health Service Corps (NHSC) provider? YES/NO
In areas designated as Health Professional Shortage Areas (HPSA) describe programmatic implications, participation in National Health Services Corp (NHSC) and processes to maintain eligibility.

No.

2) Subcontractor Monitoring

The DHS Contract with Mental Health/Substance Abuse Local Authority states: When the Local Authority subcontracts, the Local Authority shall at a minimum:

(1) Conduct at least one annual monitoring review of each subcontractor. The Local Authority shall specify in its Area Plan how it will monitor their subcontracts.

Describe how monitoring will be conducted, what items will be monitored and how required documentation will be kept up-to-date for active subcontractors.

Before entering into an agreement with a sub-contractor, BRHD requires specific information regarding that organization such as: verification of licensure, proof of insurance, staffing, administration, and treatment or service methods. Acceptable parameters for these requirements are included in the contract.

After referring a client to a contract provider, we require regular ongoing updates and invoices regarding services specific to the client. With proper releases in place, cases are staffed and services coordinated. Upon completion of services, a discharge care plan is prepared with the client and providers to ensure a smooth transition to further care, aftercare or recovery support services. We review cases and billings before payment of invoices. We conduct audits and peer reviews yearly, at a minimum, and more frequently as needed. Program reviews are done in person by authorized BRHD personnel.